

Traumatic Injury and Claim for
Continuation of Pay/Compensation

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Program.



Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.

Witness: Complete bottom section 16.

Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle)				2. Social Security Number	
3. Date of birth Mo. Day Yr. [][] [][] [][]	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Home telephone	6. Grade as of date of injury Level Step		
7. Employee's home mailing address (Include city, state, and ZIP code)				8. Dependents <input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other	

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)

10. Date injury occurred Mo. Day Yr. [][] [][] [][]	Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	11. Date of this notice Mo. Day Yr. [][] [][] [][]	12. Employee's occupation
13. Cause of injury (Describe what happened and why)			

14. Nature of injury (Identify both the injury and the part of the body, e.g., fracture of left leg)	a. Occupation code	
	b. Type code	c. Source code
	OWCP Use - NOI Code	

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injury myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

- ☐ a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.
- ☐ b. Sick and/or Annual Leave

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf _____

Date _____

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Name of witness	Signature of witness	Date signed
Address	City	State ZIP code

Official Supervisor's Report: Please complete information requested below:**Supervisor's Report**

17. Agency name and address of reporting office (Include city, state, and ZIP code)	OWCP Agency Code
	OSHA Site Code
18. Employee's duty station (Street address and ZIP code) ZIP Code	

19. Employee's retirement coverage ☐ CSRS ☐ FERS ☐ Other (Identify)

20. Regular work hours From: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. To: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	21. Regular work schedule <input type="checkbox"/> Sun <input type="checkbox"/> Mon. <input type="checkbox"/> Tues. <input type="checkbox"/> Wed. <input type="checkbox"/> Thurs. <input type="checkbox"/> Fri. <input type="checkbox"/> Sat.
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22. Date of injury Mo. Day Yr. <input type="text"/>	23. Date notice received Mo. Day Yr. <input type="text"/>	24. Date stopped work Mo. Day Yr. <input type="text"/> Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
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25. Date pay stopped Mo. Day Yr. <input type="text"/>	26. Date 45 day period began Mo. Day Yr. <input type="text"/>	27. Date returned to work Mo. Day Yr. <input type="text"/> Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
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28. Was employee injured in performance of duty? ☐ Yes ☐ No (If "No," explain)29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? ☐ Yes (If "Yes," explain) ☐ No

30. Was injury caused by third party? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," go to item 32.)	31. Name and address of third party (Include city, state, and ZIP code)
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32. Name and address of physician first providing medical care (Include city, state, ZIP code)	33. First date medical care received Mo. Day Yr. <input type="text"/>
	34. Do medical reports show employee is disabled for work? <input type="checkbox"/> Yes <input type="checkbox"/> No

35. Does your knowledge of the facts about this injury agree with the statements of the employee and/or witness? ☐ Yes ☐ No (If "No," explain)

36. If the employing agency controverts continuation of pay, state the reason in detail.	37. Pay rate when employee stopped work \$ <input type="text"/> per
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Signature of Supervisor and Filing Instructions

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of supervisor (Type or print)	
Signature of supervisor	Date
Supervisor's Title	Office phone

39. Filing instructions
- ☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
 - ☐ No lost time, medical expense incurred or expected: forward this form to OWCP
 - ☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP
 - ☐ First Aid Injury

Instructions for Completing Form CA-1

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. Some of the items on the form which may require further clarification are explained below.

Employee (Or person acting on the employee's behalf)

13) Cause of Injury

Describe in detail how and why the injury occurred. Give appropriate details (e.g.: if you fell, how far did you fall and in what position did you land?)

14) Nature of Injury

Give complete description of the condition(s) resulting from your injury. Specify the right or left side if applicable (e.g., fractured left leg; cut on right index finger).

15) Election of COP/Leave

If you are disabled for work as a result of this injury and file CA-1 within thirty days of the injury, you are entitled to receive continuation of pay (COP) from your employing agency. COP is

paid for up to 45 calendar days of disability, and is not charged against sick or annual leave. You may elect sick or annual leave if you wish, but compensation from OWCP may not be claimed during the 45 days of COP entitlement. (You may not claim compensation to repurchase leave used during this period.) Also, if you change your election within one year, the agency is obliged to convert past periods of leave to COP, which qualify.

Your agency may controvert (dispute) your entitlement to COP, but must continue pay unless the controversion is based on one of the nine reasons listed in the instructions for item 35.

If you receive COP, but OWCP later determines that you are not entitled to COP, you may either change COP to sick or annual leave or pay the employing agency back for the COP received.

Supervisor

At the time the form is received, complete the receipt of notice of injury and give it to the employee. In addition to completing items 17 through 38, the supervisor is responsible for obtaining the witness statement in item 16 and for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form should be sent to OWCP within 10 working days after it is received.

The supervisor should also submit any other information or evidence pertinent to the merits of this claim.

If the employing agency controverts COP, the employee should be notified and the reason for controversion explained to him or her.

17) Agency name and address of reporting office

The name and address of the office to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation office).

18) Duty station street address and zip code

The address and zip code of the establishment where the employee actually works.

19) Employees Retirement Coverage.

Indicate which retirement system the employee is covered under.

30) Was injury caused by third party?

A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer whose defective product causes an employee's injury, could all be considered third parties to the injury.

32) Name and address of physician first providing medical care

The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.

33) First date medical care received

The date of the first visit to the physician listed in item 32.

36) Does the employing agency controvert continuation of pay?

COP may be controverted (disputed) for any reason; however, the employing agency may refuse to pay COP only if the controversion is based upon one of the nine reasons given below:

- a) The disability results from an occupational disease or illness;
- b) The employee is a volunteer working without pay or for nominal pay, or a member of the office staff of a former President;
- c) The employee is neither a citizen or a resident of the United States or Canada;
- d) The injury occurred off the employing agency's premises and the employee was not involved in official "off premise" duties;
- e) The injury was approximately caused by the employee's willful misconduct, intent to bring about injury or death to self or another person, or intoxication;
- f) The injury was not reported on Form CA-1 within 30 days following the injury;
- g) Work stoppage first occurred 90 days or more following the injury;
- h) The employee initially reported the injury after his or her employment was terminated; or
- i) The employee is enrolled in the Civil Air Patrol, Peace Corps, Youth Conservation Corps, Work Study Programs, or other similar groups.

Employing Agency - Required Codes

Box a (Occupation Code), Box b (Type Code), Box c (Source Code), OSHA Site Code

The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, "Recordkeeping and Reporting Guidelines."

OWCP Agency Code

This is a four-digit (or four digit plus two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

Disability Benefits for Employees under the Federal Employees' Compensation Act (FECA)

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following benefits for job-related traumatic injuries:

- (1) Continuation of pay for disability resulting from traumatic, job-related injury, not to exceed 45 calendar days. (To be eligible for continuation of pay, the employee, or someone acting on his/her behalf, must file Form CA-1 within 30 days following the injury; however, to avoid possible interruption of pay, the form should be filed within 2 working days. If the form is not filed within 30 days, compensation may be substituted for continuation of pay.)
- (2) Payment of compensation for wage loss after the 45 days, if disability extends beyond such period.
- (3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious disfigurement of the head, face, or neck.
- (4) Vocational rehabilitation and related services where necessary.
- (5) Full medical care from either Federal medical officers and hospitals, or private hospital or physicians, of the employee's choice. Generally, 25 miles from the place of injury, place of employment, or employee's home is a reasonable distance to travel for medical care; however, other pertinent facts must also be considered in making selection of physician or medical facilities.

At the time an employee stops work following a traumatic, job-related injury, he or she may request continuation of pay or use sick or annual leave credited to his or her record. Where the employing agency continues the employee's pay, the pay must not be interrupted until:

- (1) The employing agency receives medical information from the attending physician to the effect that disability has terminated;
- (2) The OWCP advises that pay should be terminated; or
- (3) The expiration of 45 calendar days following initial work stoppage.

If disability exceeds, or it is anticipated that it will exceed, 45 days, and the employee wishes to claim compensation, Form CA-7, with supporting medical evidence, must be filed with OWCP. To avoid interruption of income, the form should be filed on the 40th day of the COP period. Form CA-3 shall be submitted to OWCP when the employee returns to work, disability ceases, or the 45 days period expires.

An employee may use sick or annual leave rather than LWOP while disabled. The employee may repurchase leave used for approved periods. Form CA-7b, available from the personnel office, should be studied BEFORE a decision is made to use leave.

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Title 20, Chapter 1) or Chapter 810 of the Office of Personnel Management's Federal Personnel Manual.

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of the Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehiring, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the FECA.

Receipt of Notice of Injury

This acknowledge receipt of Notice of Injury sustained by
(Name of injured employee)

Which occurred on (Mo., Day, Yr.)

At (Location)

Signature of Official Superior

Title

Date (Mo., Day, Yr.)